Garrison Care:
The Patient Centered Medical Home and our Active Duty

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Disclosure Statement

Maureen Baldwin and all others involved in the planning, development and presentation of this CME activity provide the following Disclosure information:

"Nothing to disclose"

History of PCMH

- Roots in the civilian healthcare system
- Joint Principles of the PCMH published by AAFP, AAP and ACP in 2007
- Approach to providing comprehensive primary care that emphasizes patient/provider relationship
- Leverages team to provide coordinated care
- Facilitates partnership
- Not brick and mortar; concept of care
- Anchored in quality and safety

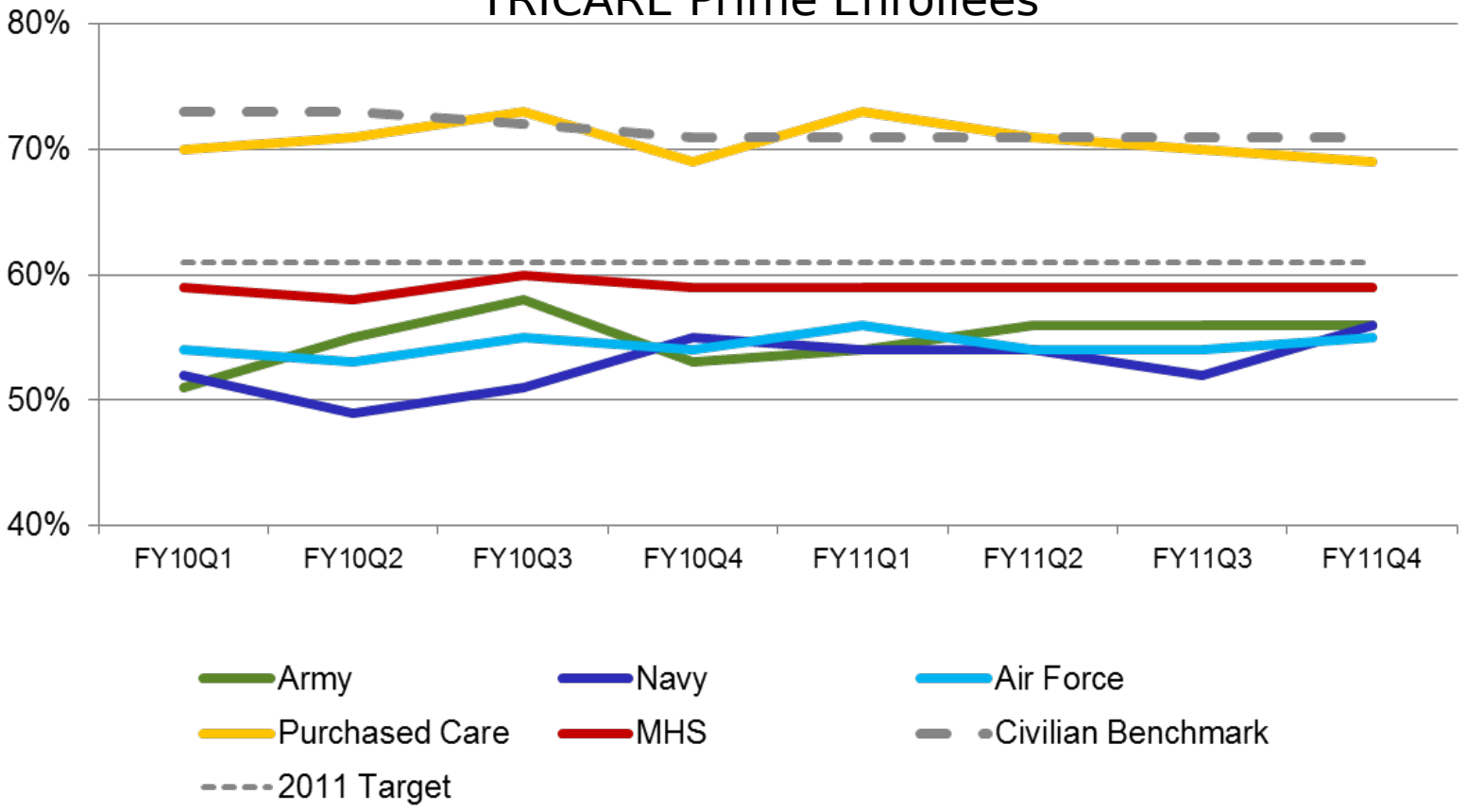
PCMH Strategy

- Improve physician / patient relationship
- Improve access, quality and control cost of care
- Increased costs and poorer health outcomes when compared to other developing countries
  - U.S. ranks # 37 in quality but #1 in per capita costs
- High utilization of technology/procedures in US:
  - Drives misperception that healthcare is too expensive
  - Overuse exposes patients to potential adverse events and errors
- Inappropriate use of the ER for primary care

Patient Satisfaction with MHS

Top Customer Service Issues*:
Getting appointments, Clinic wait times, Specialist availability, Finding parking

Satisfaction with Health Care
TRICARE Prime Enrollees



Source: *DMDC Survey Oct ’10 -Tricare Update SECNAV Retiree Council April 2012

Improving the US Healthcare System

npr
Pentagon To Cut $78 Billion Over 5 Years
U.S.News & WORLD REPORT
New Healthcare Reform Provisions Go Into Effect
THE WALL STREET JOURNAL.
Pentagon Faces the Knife
Forbes
Giving Credit Where It's Due: Health Reform Promotes Radical Transparency
The New York Times
Gates Seeking to Contain Military Health Costs
KHN
KAISER HEALTH NEWS
DOD Struggles With Health Care Costs, VA Faces Challenges In Providing Care
GAO Report Finds Integrated Systems Improve Care and Access, but Still Face Challenges

- Everyone facing same challenges (Air Force, Army, VA, Civilians, etc)
- U.S.: #1 for costs; 37th in quality
- DoD healthcare inflation unsustainable
- DoD beneficiaries less satisfied with direct care
- Sequestration

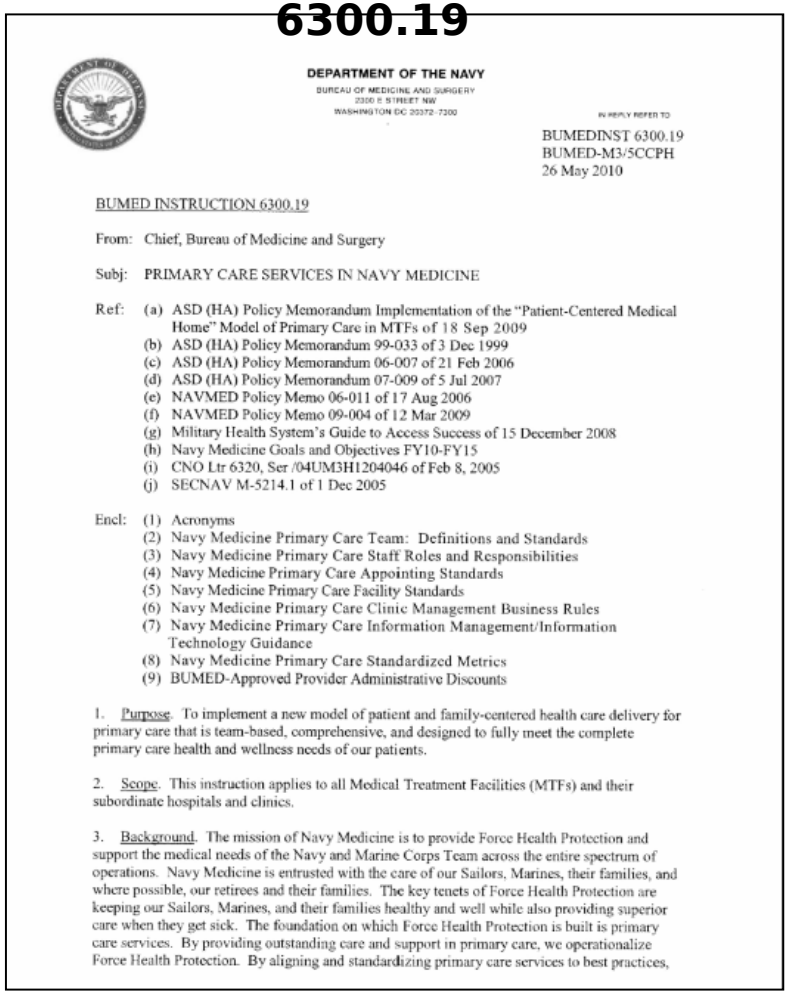
Solutions limited:

- Raise TRICARE fees (increase cost sharing)
- Cut services / shrink coverage
- Become more efficient

NAVY MEDICINE

MHP: Navy's Version of PCMH Model

NAVMED INST 6300.19



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-7300

IN REPLY REFER TO
BUMEDINST 6300.19
BUMED-M3/5CCPH
26 May 2010

BUMED INSTRUCTION 6300.19

From: Chief, Bureau of Medicine and Surgery

Subj: PRIMARY CARE SERVICES IN NAVY MEDICINE

Ref: (a) ASD (HA) Policy Memorandum Implementation of the "Patient-Centered Medical Home" Model of Primary Care in MTFs of 18 Sep 2009
(b) ASD (HA) Policy Memorandum 99-033 of 3 Dec 1999
(c) ASD (HA) Policy Memorandum 06-007 of 21 Feb 2006
(d) ASD (HA) Policy Memorandum 07-009 of 5 Jul 2007
(e) NAVMED Policy Memo 06-011 of 17 Aug 2006
(f) NAVMED Policy Memo 09-004 of 12 Mar 2009
(g) Military Health System's Guide to Access Success of 15 December 2008
(h) Navy Medicine Goals and Objectives FY10-FY15
(i) CNO Ltr 6320, Ser /04UM3H1204046 of Feb 8, 2005
(j) SECNAV M-5214.1 of 1 Dec 2005

Encl: (1) Acronyms
(2) Navy Medicine Primary Care Team: Definitions and Standards
(3) Navy Medicine Primary Care Staff Roles and Responsibilities
(4) Navy Medicine Primary Care Appointing Standards
(5) Navy Medicine Primary Care Facility Standards
(6) Navy Medicine Primary Care Clinic Management Business Rules
(7) Navy Medicine Primary Care Information Management/Information Technology Guidance
(8) Navy Medicine Primary Care Standardized Metrics
(9) BUMED-Approved Provider Administrative Discounts

1. Purpose. To implement a new model of patient and family-centered health care delivery for primary care that is team-based, comprehensive, and designed to fully meet the complete primary care health and wellness needs of our patients.

2. Scope. This instruction applies to all Medical Treatment Facilities (MTFs) and their subordinate hospitals and clinics.

3. Background. The mission of Navy Medicine is to provide Force Health Protection and support the medical needs of the Navy and Marine Corps Team across the entire spectrum of operations. Navy Medicine is entrusted with the care of our Sailors, Marines, their families, and where possible, our retirees and their families. The key tenets of Force Health Protection are keeping our Sailors, Marines, and their families healthy and well while also providing superior care when they get sick. The foundation on which Force Health Protection is built is primary care services. By providing outstanding care and support in primary care, we operationalize Force Health Protection. By aligning and standardizing primary care services to best practices,

- Medical Home Port (MHP) Instruction addresses the following:
  - Changes in staff roles and responsibilities (e.g. team-based approach to care)
  - Changes in business rules (e.g. enrollment and patient management, appointing, access)
  - Use of Information Management/Information Technology (IM/IT) tools (e.g. secure messaging, clinical informatics tools)
  - Evaluating MHP using standardized metrics (e.g. NCQA evaluation)

Medical Home vs Managed Care

- Medical Home means
  - Physician-patient relationship
  - Patient-centered, personalized care
  - Preventive services, fewer ER visits
  - Less hospitalization, better tracking
  - Physician support and feedback
  - Healthier, engaged patients
  - Fiscal savings through comprehensive, coordinated care
- Managed Care means
  - Systematic “gatekeeper” relationship
  - Contractually-dictated care
  - Patients get “partialist” care with services carved out
  - Physicians handcuffed by “one size fits all model”
  - More rules and unhappy patients
  - Fiscal savings by limiting access to services

Source: Illinois Academy of Family Physicians

Principles of the Marine Centered Medical Home

1. Every Marine will have an assigned Primary Care Manager (PCM) by name.
2. The PCM will be a Navy Medical Department provider most often assigned to the Operational Forces.
3. PCM's by policy can be physicians, nurse practitioners, physician assistants or Independent Duty Corpsman.
4. Marine Corps organic health services are organized to optimally support operational expeditionary missions, not a garrison Medical Home Model. Despite this, Marine Corps organic health services will maximally support the Marine Centered Medical Home in garrison and while forward deployed.
5. Garrison PCM's will be organized into Medical Home teams consisting of a small provider groups equaling three to five full time equivalents (FTE). Their ancillary staff must be of sufficient size and availability to provide open access to their assigned patients. Teams will be organized in a manner that aligns with the organizational structure present at that specific location.
6. Expansion of the garrison healthcare team to include Registered Nurses (RNs) as care managers and administrative clerks is permissible in order to improve population health management.
7. Non-residency trained/board certified General Medical Officers (GMO) serving as PCM's will establish

MOU Signed Between HQMC and BUMED

   c. Marine Centered Medical Home teams will use evidence based clinical decision support tools in the delivery of healthcare to their patients.
   d. Performance improvement and quality assurance activities will be consistent with those practiced within the community as described by The Joint Commission.
   e. Proactive, population based health management will be embraced by the Marine Centered Medical Home team.
   f. Beneficiaries of the Marine Centered Medical Home will be surveyed regularly regarding the quality of the healthcare they receive in alignment with other beneficiaries of DoD sponsored healthcare.
   g. Marine Centered Medical Home teams will undergo a voluntary recognition process to evaluate their ability to deliver healthcare as a medical home. Such recognition could be sought from the National Committee for Quality Assurance (NCQA) or through assessment by the Marine Corps Inspector General.
10. Marines/Sailors will be provided enhanced access to care when compared with traditional practice:
   a. The continuity of patient encounters with the assigned PCM by name will be maximized; when the PCM is not available, the Marine/Sailor will be seen by another familiar provider on the Medical Home team.
   b. Marines/Sailors will be provided same day provider availability for healthcare when requested, otherwise, a routine healthcare appointment will be available within 7 days for any health issue.
   c. Marine Centered Medical Home teams will template sufficient clinic availability to meet the demand of their patients for healthcare.
   d. Expanded hours will be utilized to provide patient centered access to care that promotes availability of appointments that minimize interference with the mission.
   e. Marine Centered Medical Home teams will utilize technology such as secure messaging and telephone consultation to deliver services when appropriate.

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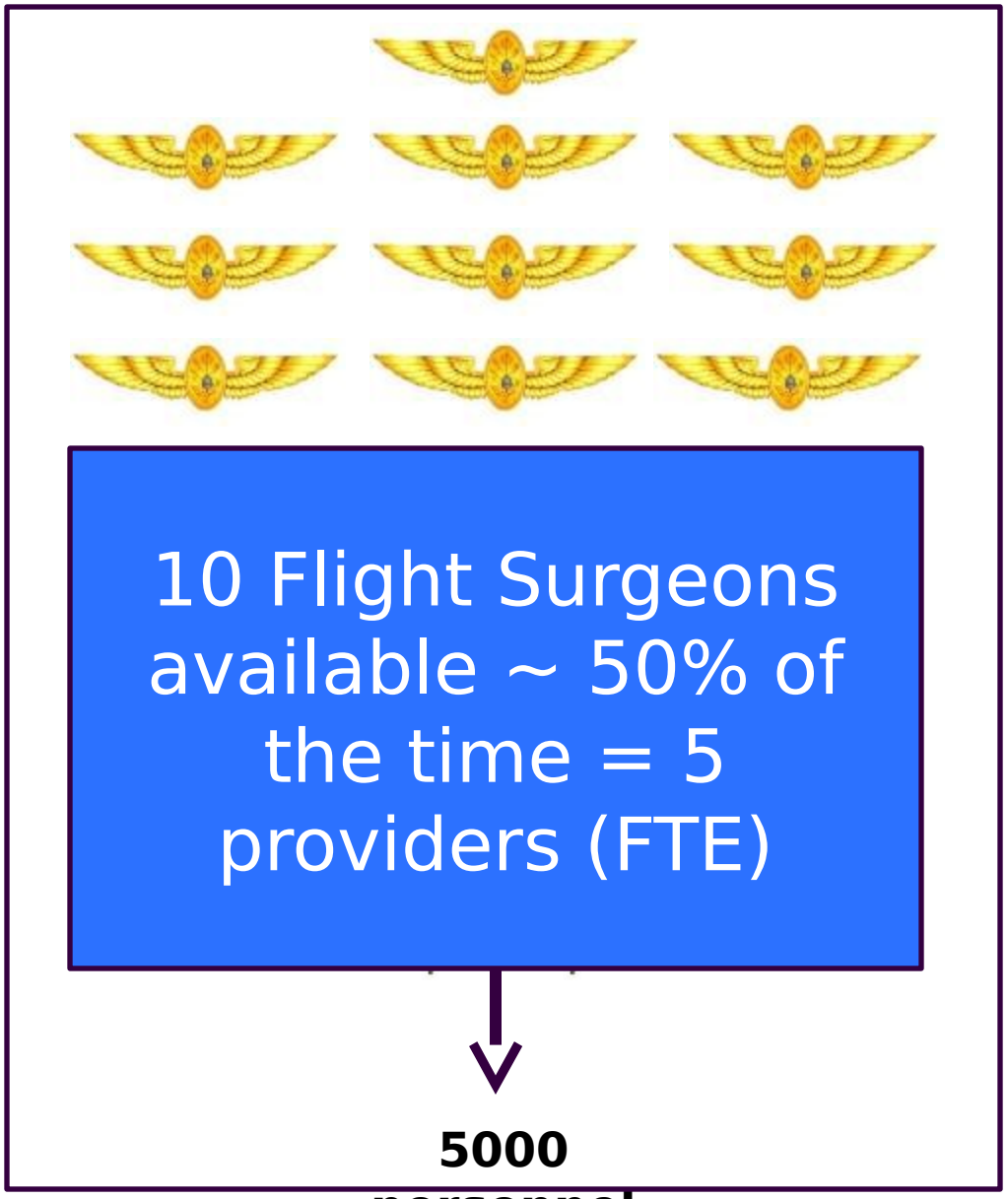
Enrollment in the Medical Home

- FCMH/MCMH seeks to evolve BMC's/FLC's to micro-practices
- Adjustments for other duties outside face to face continuity practice
- Successful planning will have impact on:
  - Readiness
  - PCMBN continuity
  - Team continuity
  - ER utilization and other leaks of primary care
  - Performance on quality metrics
  - Costs
  - Patient satisfaction

Traditional → Group Practice Model

250 personnel



10 Flight Surgeons available ~ 50% of the time = 5 providers (FTE)

5000 personnel

What is the demand for care?

- Same day access (1.0%) of population
- Future pre-booked access (0.5%)
- Assume team of 4,000 active duty from 10 various squadrons and units combined:
  - 40 same day appointments (ACUT)
  - 20 future book appointments (EST)
  - Total visits: 60 each day for clinic (high end)
- If we assume a provider could see 20 patients a day, requirement is for 3 FTE…other 7 remain in squadron duties (doesn’t include Flight PE’s)
- Integrated practice, scalable in response to deployments…FS goes with unit

Standardized Appointing Supports Patient-Centered Care

ACUT	EST	PROC/SPEC
• Release and begin booking appointments up to 24 hours out for any reason	• Future appointments used for all care outside the 24 hour window	• Non-continuity services • Walk in immunizations • Flight Physicals

Appointing Goals

- **EST**: Third Next Available <7 days
- **ACUT**: Within 24 hours for same day care
- SPEC: Flight Physicals / Up chits
- PROC: Immunizations Procedures

- **Appointment Mix of ACUT/EST: Probably 70% ACUT / 30% in operational world**

Do Today's Work Today!

Today’s Work Today

- Do everything same day as much as possible
- Regardless of acuity
- Decreases no shows
- Preserves maximum capacity for tomorrow and beyond
- Only two types of good backlog:
  - Medical need to schedule in the future
  - Patient preference
- Otherwise, see it today!!

Standardized Continuity Template

Morning

Check In	Physician	Type
7:45:00 AM	8:00:00 AM	ACUT
8:00:00 AM	8:20:00 AM	ACUT
8:20:00 AM	8:40:00 AM	ACUT
8:40:00 AM	9:00:00 AM	ACUT
9:00:00 AM	9:20:00 AM	EST
9:20:00 AM	9:40:00 AM	ACUT
9:40:00 AM	10:00:00 AM	EST
10:00:00 AM	10:20:00 AM	ACUT
10:20:00 AM	10:40:00 AM	ADD-ON
10:40:00 AM	11:00:00 AM	ADD-ON
11:00:00 AM	11:20:00 AM	ADMIN
11:20:00 AM	11:40:00 AM	ADMIN

Afternoon

Check In	Physician	Type
12:45:00 PM	1:00:00 PM	ACUT
1:00:00 PM	1:20:00 AM	ACUT
1:20:00 PM	1:40:00 AM	ACUT
1:40:00 PM	2:00:00 PM	ACUT
2:00:00 PM	2:20:00 PM	EST
2:20:00 PM	2:40:00 PM	ACUT
2:40:00 PM	3:00:00 PM	EST
3:00:00 PM	3:20:00 PM	ACUT
3:20:00 PM	3:40:00 PM	ADD-ON
3:40:00 PM	4:00:00 PM	ADD-ON
4:00:00 PM	4:20:00 PM	ADMIN
4:20:00 PM	4:40:00 PM	ADMIN

Typical Navy Med Home Port Team

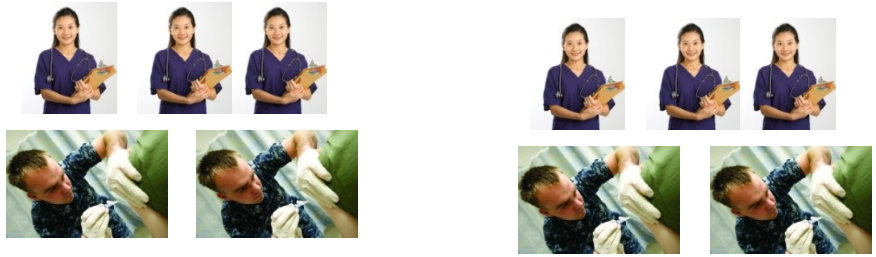
C-FTE

Equivalent to 4 providers (not bodies)

0.5 RN/c-FTE

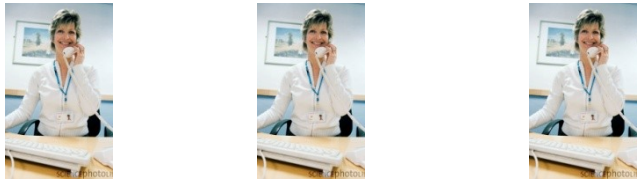
2 nurses

2.5 CMA/c-FTE



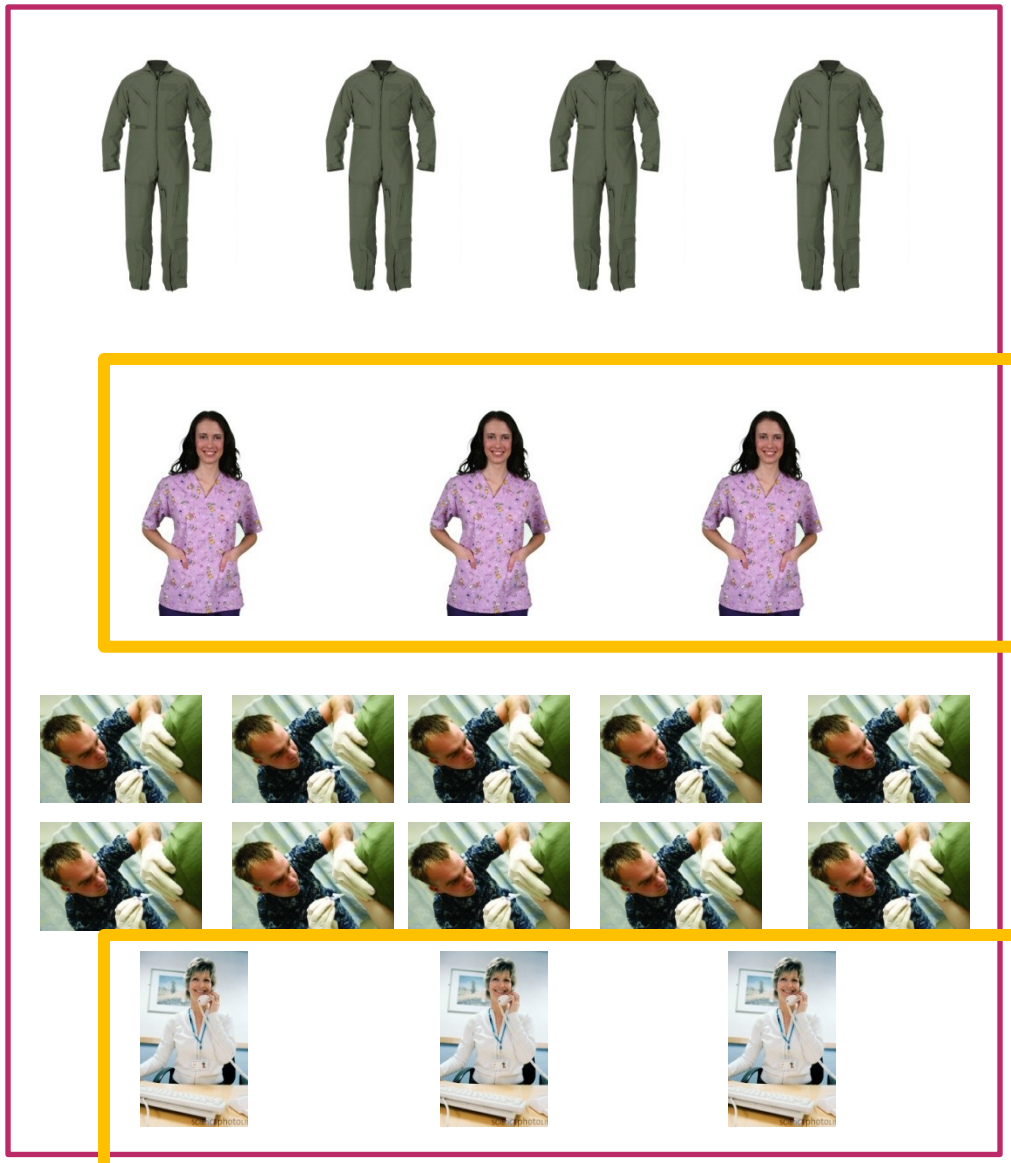
10 medical assistants

0.75 clerk/c-FTE



3 clerks

Fleet Centered Med Home Team



Equivalent to 4 providers (not bodies)

1RN & 1 LPN & 1 Care Coord.

~10 HMs

1-3 clerks

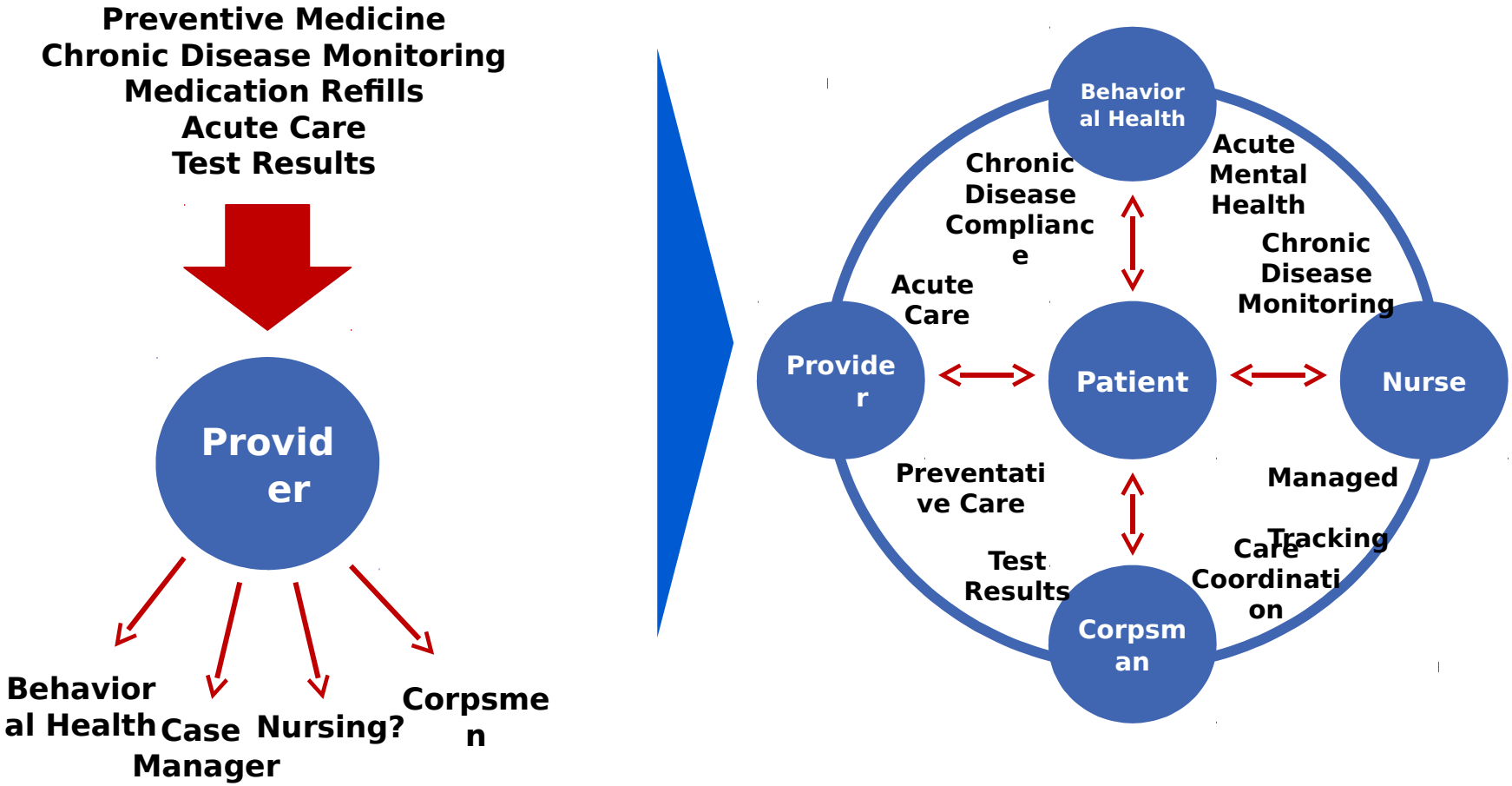
FCMH Test Sites

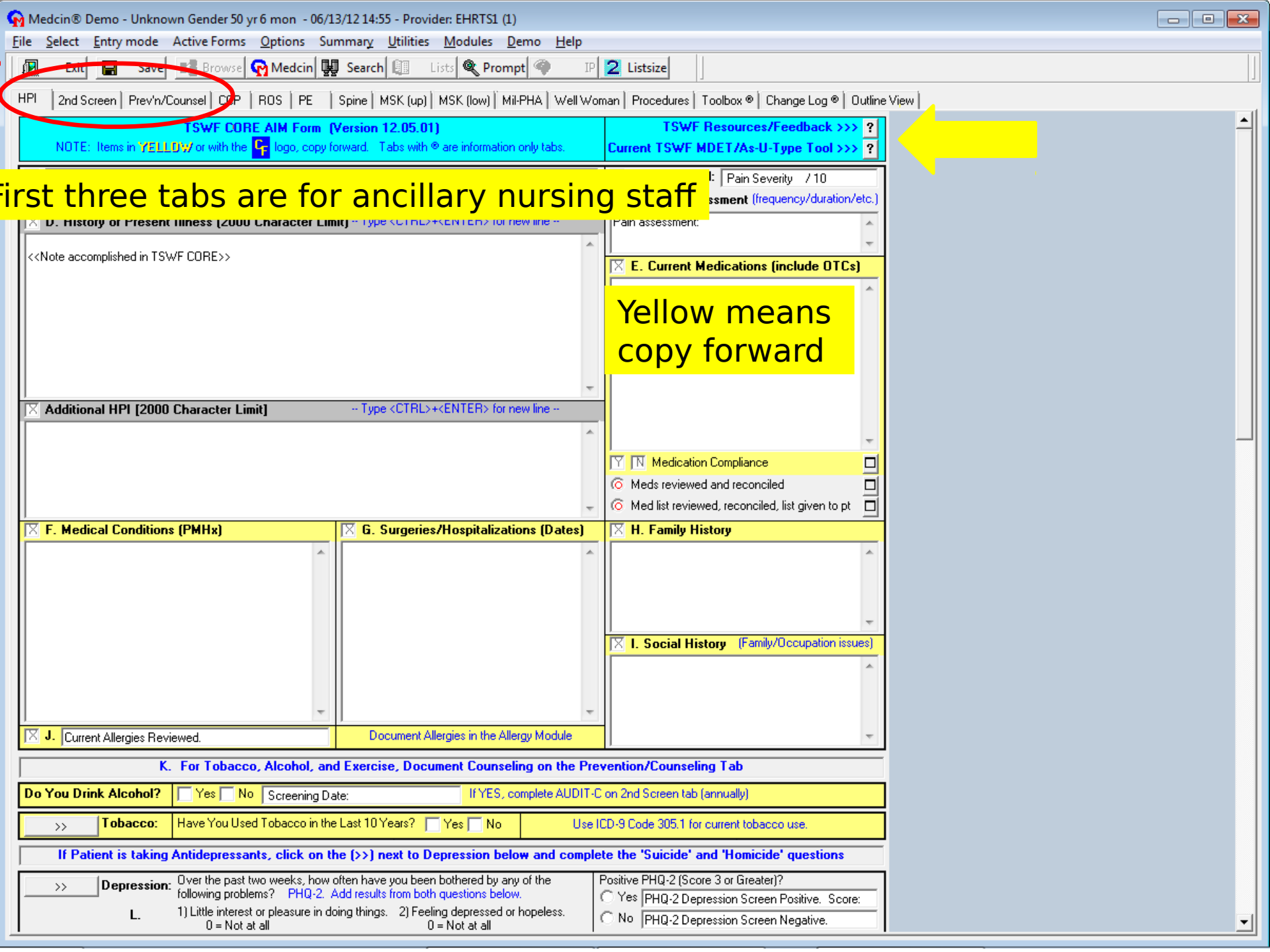
- Cherry Point (Marine Air)
- Camp Lejeune (Marine Logistics Regiment)
- Gulfport (Seabees)
- NAS North Island (Navy Air)
- NAS Whidby Island (Navy Air)
- Camp Pendleton (Marine Infantry)
- Okinawa (Marines @ Kinser / Hansen)

A Redesigned Workflow Better Leverages FCMH Team Members

Traditional Workflow: Provider-Centered

Future Workflow: Team-Based Approach




Medcin® Demo - Unknown Gender 50 yr 6 mon - 06/13/12 14:55 - Provider: EHRTS1 (1)
File Select Entry mode Active Forms Options Summary Utilities Modules Demo Help
Exit Save Browse Medcin Search Lists Prompt IP Listsize
HPI 2nd Screen Prev'n/Counsel COP ROS PE Spine MSK (up) MSK (low) Mil-PHA Well Woman Procedures Toolbox ® Change Log ® Outline View
TSWF CORE AIM Form (Version 12.05.01)
NOTE: Items in YELLOW or with the CF logo, copy forward. Tabs with ® are information only tabs.
TSWF Resources/Feedback >>>
Current TSWF MDET/As-U-Type Tool >>>
First three tabs are for ancillary nursing staff
Pain Severity / 10
ssment (frequency/duration/etc.)
Pain assessment:
D. History of Present Illness (2000 Character Limit) -- Type <CTRL>+<ENTER> for new line --
<<Note accomplished in TSWF CORE>>
E. Current Medications (include OTCs)
Yellow means copy forward
Additional HPI [2000 Character Limit] -- Type <CTRL>+<ENTER> for new line --
Medication Compliance
Meds reviewed and reconciled
Med list reviewed, reconciled, list given to pt
F. Medical Conditions (PMHx)
G. Surgeries/Hospitalizations (Dates)
H. Family History
I. Social History (Family/Occupation issues)
J. Current Allergies Reviewed.
Document Allergies in the Allergy Module
K. For Tobacco, Alcohol, and Exercise, Document Counseling on the Prevention/Counseling Tab
Do You Drink Alcohol? Yes No Screening Date: If YES, complete AUDIT-C on 2nd Screen tab (annually)
>> Tobacco: Have You Used Tobacco in the Last 10 Years? Yes No Use ICD-9 Code 305.1 for current tobacco use.
If Patient is taking Antidepressants, click on the (>>) next to Depression below and complete the 'Suicide' and 'Homicide' questions
>> Depression: L. Over the past two weeks, how often have you been bothered by any of the following problems? PHQ-2. Add results from both questions below.
1) Little interest or pleasure in doing things. 0 = Not at all
2) Feeling depressed or hopeless. 0 = Not at all
Positive PHQ-2 (Score 3 or Greater)?
Yes PHQ-2 Depression Screen Positive. Score:
No PHQ-2 Depression Screen Negative.

Medcin® Demo - Unknown Gender 50 yr 6 mon - 06/13/12 14:55 - Provider: EHRTS1 (1)

File Select Entry mode Active Forms Options Summary Utilities Modules Demo Help

Exit | Save | Browse | Medcin | Search | Lists | Prompt | IP | 2 Listsize

HPI | 2nd Screen | Prev'n/Counsel | CCP | ROS | PE | Spine | MSK (up) | MSK (low) | Mil-PHA | Well Woman | Procedures | Toolbox ® | Change Log ® | Outline View

K. For Tobacco, Alcohol, and Exercise, Document Counseling on the Prevention/Counseling Tab

Do You Drink Alcohol? ☐ Yes ☐ No Screening Date: If YES, complete AUDIT-C on 2nd Screen tab (annually)

<< **Tobacco:** Have You Used Tobacco in the Last 10 Years? ☐ Yes ☐ No Use ICD-9 Code 305.1 for current tobacco use.

☒ Current User /Tobacco Use: Type/Amt per Day: ☒ Smoking History / Tobacco Use. Quit Date: ☐ N Desire to Quit ☐

If Patient is taking Antidepressants, click on the (>>) next to Depression below and complete the 'Suicide' and 'Homicide' questions

<< **Depression:** Over the past two weeks, how often have you been bothered by any of the following problems? PHQ-2. Add results from both questions below.

L.

1) Little interest or pleasure in doing things.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

2) Feeling depressed or hopeless.
0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly every day

Positive PHQ-2 (Score 3 or Greater)?
○ Yes PHQ-2 Depression Screen Positive. Score:
○ No PHQ-2 Depression Screen Negative.
If Yes, Alert Provider. Document Suicidal and / or Homicidal Ideation below and accomplish Full PHQ-9 via the link below or on Secondary Screening tab

☐ N Thinking About Suicide ☐ ☐ N Thinking About Homicide ☐ **Patient Health Questionnaire (PHQ-9) >** ?

Female ONLY Data

☐ N Could You Be Pregnant ☐ ☒ Pregnant for ___ Weeks Based on LMP Date of Last Period: ☒ ☐ U Date: U = Unknown

M. Joint Commission / AAAHC / HSI Related

Patient's Overall Feeling	○ Excellent	○ Very Good	○ Good	○ Fair ○ Poor
Feels Safe at Home?	○ Yes ☐			○ No ☐
Deployment Related?	☐ Yes ☐ No			<<< If visit is deployment related, enter Location and Date
Active Duty?	☐ Yes ☐ No	○ A PHA has been completed in past year. Date:		○ A PHA has NOT been completed in the past year.

☒ **N. Additional JC / AAAHC / HSI** (Ask Questions Annually and Record Screening Date)

ANNUAL SCREENING DATE:

What is your preferred method of learning? [ ]Verbal [ ]Written [ ]Visual [ ]Other (Specify):
Do you have a learning disability, language barrier, hearing/vision deficit? [ ]Yes [ ]No Specify:
Advanced directives completed? [ ]Yes [ ]No
Do you have any cultural or religious beliefs that may affect your care? [ ]Yes [ ]No
Are you enrolled in EFMP? [ ]Yes [ ]No
Do you use a Personal Health Record (PHR)? [ ]Yes [ ]No Specify:
Contact info:

PRP / SCI / PSP / SPECIAL DUTY

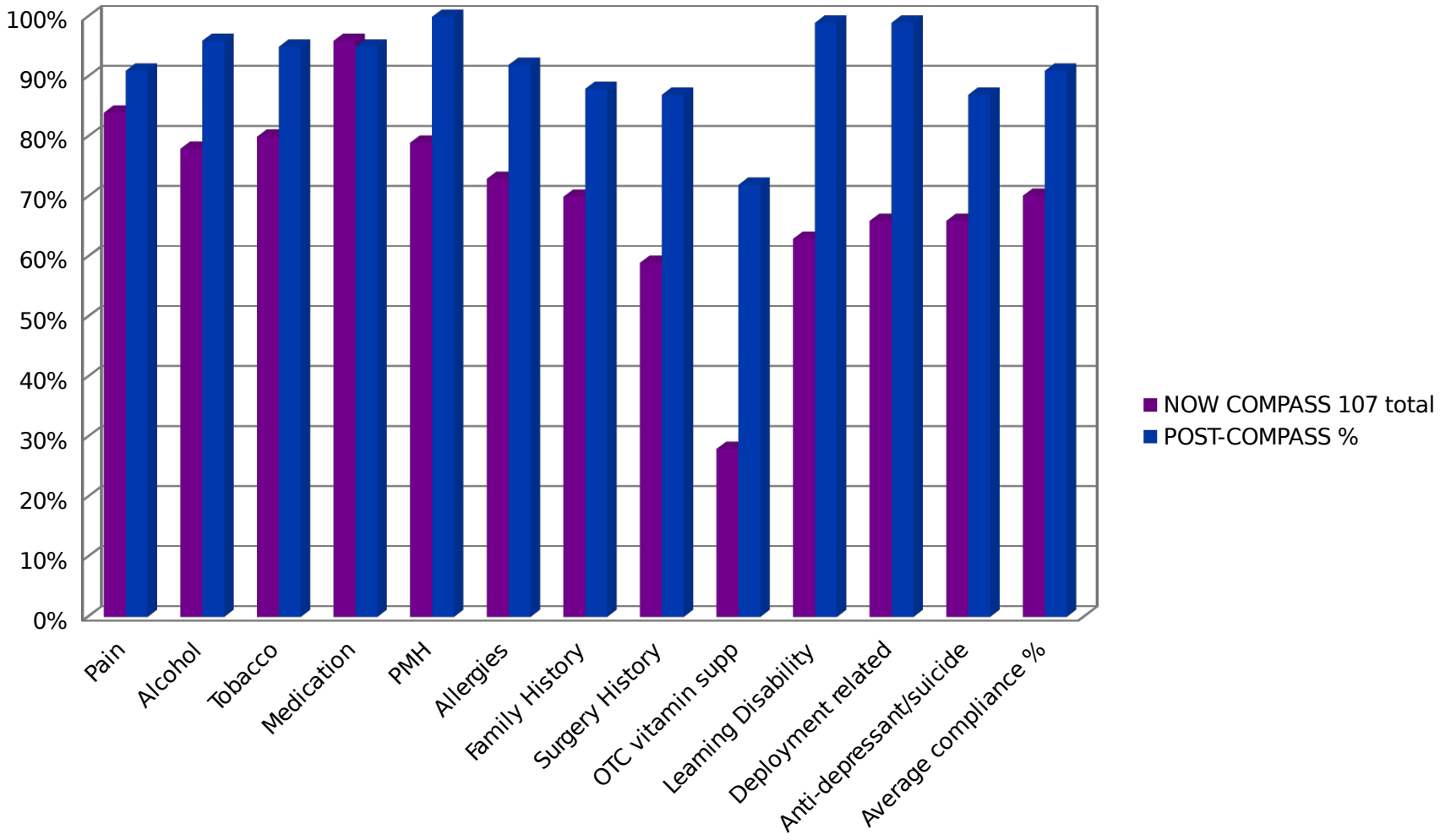
☐ N **PRP (Personnel Reliability Program)** ☐ ☐ N **PSP (Presidential Support Program)** ☐

☐ N **SCI (Sensitive Compartmented Information) Authorized** ☐ ☒ **Special Duty** [ ]Active Flying Status [ ]Diving Duty [ ]SMOD

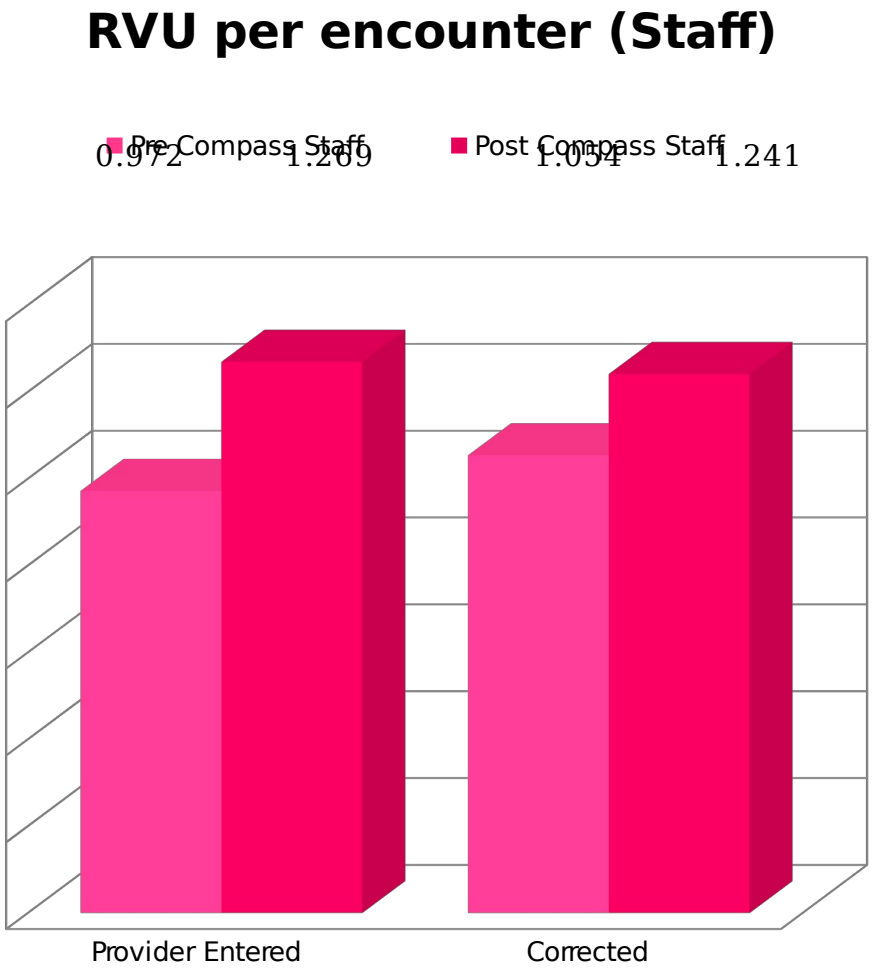
☐ N **Other Military Duty-Related Information**

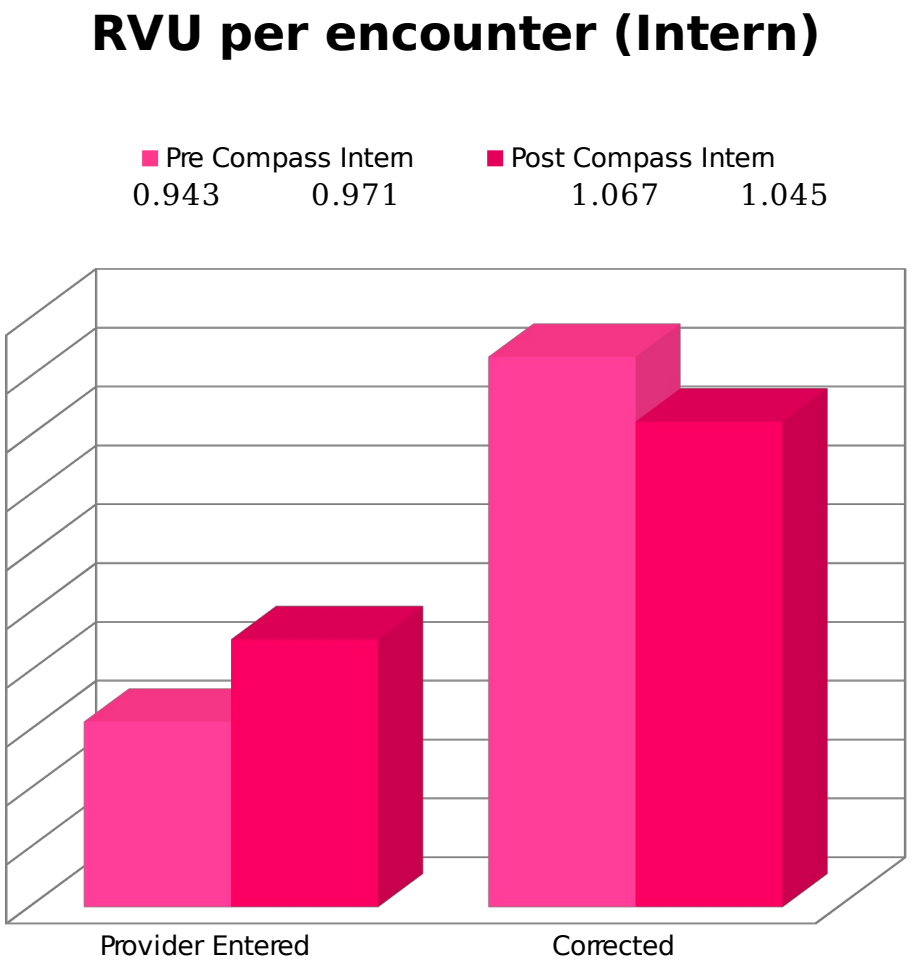
>> **Obsolete Terms** This ribbon contains terms from other forms that may Copy Forward to the note, but will NOT appear on the TSWF-CORE AIM
If terms below are selected and you do not want them in the Encounter Note, UNCHECK them now.

Workflow Research Results JC/HSI

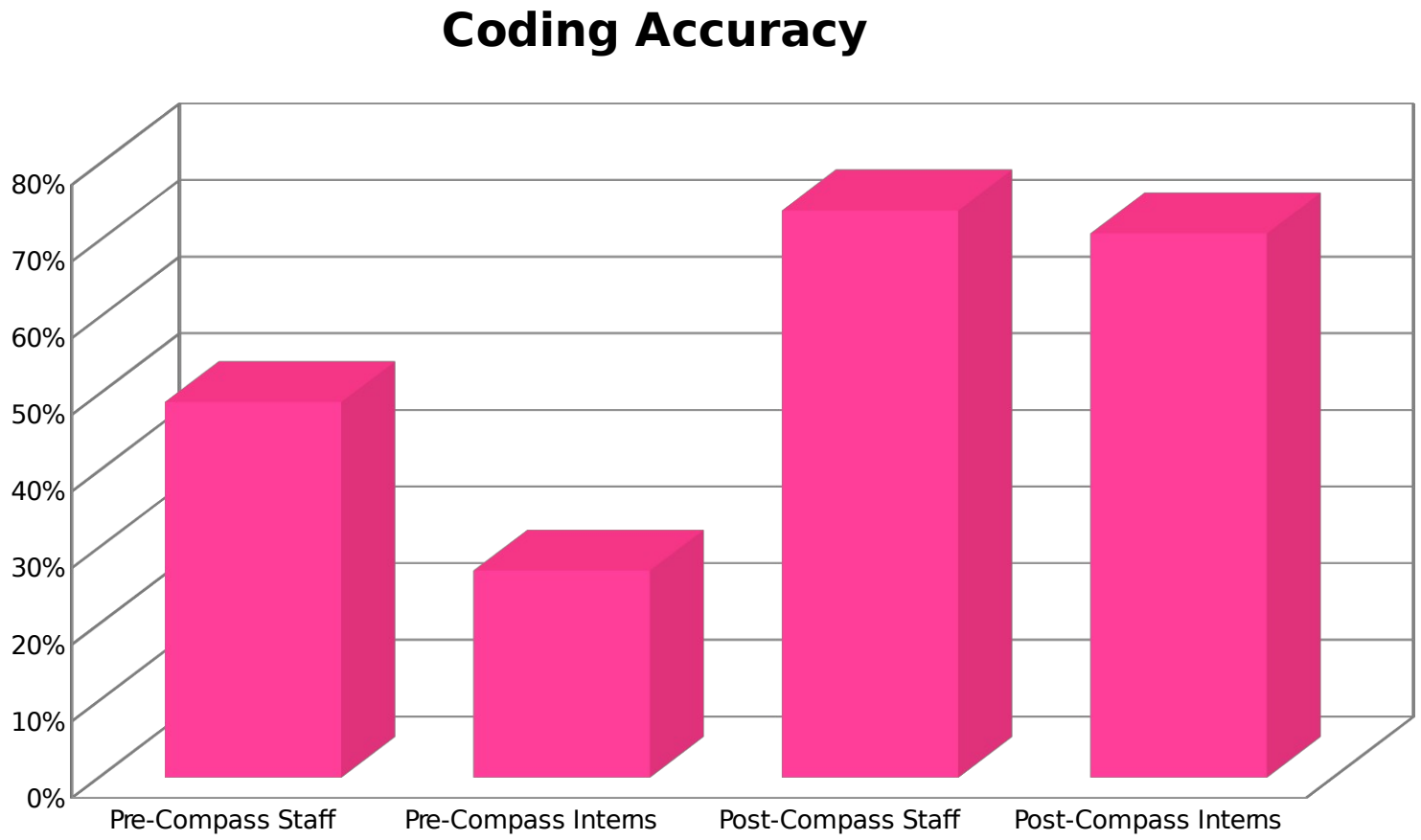


Workflow Research Results RVU's





Workflow Research Results Coding Accuracy



Anticipated Effects of FCMH

Improved:

- Access to Care
- Team continuity
- PCM continuity
- Patient satisfaction

Reduced Cost of Care:

- Unnecessary:
  - ✓ER use
  - ✓Network care
  - ✓Ancillary tests
  - ✓Hospitalizations
  - ✓Specialty visits

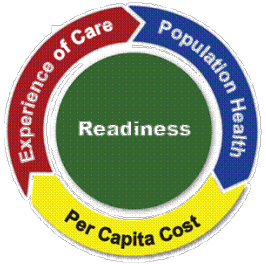
Decreasing Purchased Care

- Largest area to make significant progress is in Emergency Room use for primary care
- Top 10 ICD codes seen by AD in ER are not emergent
- Exponential growth of costs
- Goal is to bring them back into Navy Medicine facilities
- Means more fuel, aircraft and ships for CNO if we can reduce our inflation

Monitoring FCMH performance

Experience of Care

- FCMH Team Continuity
- PCM Continuity
- 3rd Next Available Acute/Routine
- Patient Satisfaction



Per Capita Cost

- % kept consult appts
- ER Utilization

Readiness

- Indeterminate
- Partially Medically Ready
- PHA completion rate
- Immunization compliance

- New metrics may be added, if mutually agreed upon

Metrics – Annual Review

2013 - 2014

Marine-Centered Medical Home (MCMH)

Background

- The Marine Centered Medical Home (MCMH) is a federated effort by USMC and Navy Medicine to EFFECTIVELY deliver high quality medical care to operational Marines in appropriate garrison medical facilities.

- MCMH is a comprehensive USMC garrison care construct modeled after similar Navy Medicine and civilian sector approaches – while respecting USMC-specific prerogatives.
  - One standard of care across Department of the Navy.
  - Enhanced access to and quality of care.
  - Integration with Navy Medical Neighborhood (IT, Sports Medicine, Behavioral Health, Ancillary support, etc.).

Background

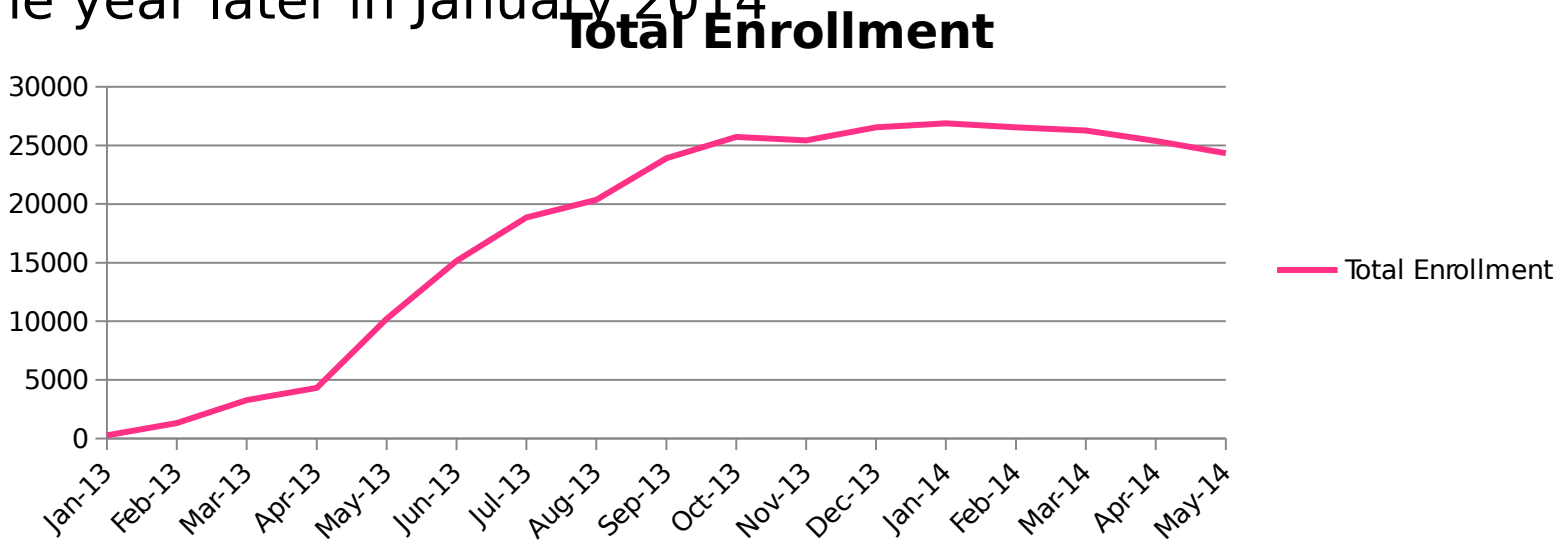
- MCMH Master Plan:
  - Six (6) pilot sites initiated 23Jan2013.
  - Expand to 17 more sites in FY15.
  - A final eight (8) sites require MILCON.
    - 29 Palms estimated complete in late FY14/early FY15.
    - Kaneohe Bay construction scheduled to start in FY16.
    - Six (6) other sites require new construction or expansion to meet final requirements.

- Behavioral Health Integration Program (BHIP)
  - Separate DoD program embedding Behavioral Health provider in primary care clinics.
  - HQMC (HS) and BUMED have linked this program directly to MCMH.

Enrollment

BLUF

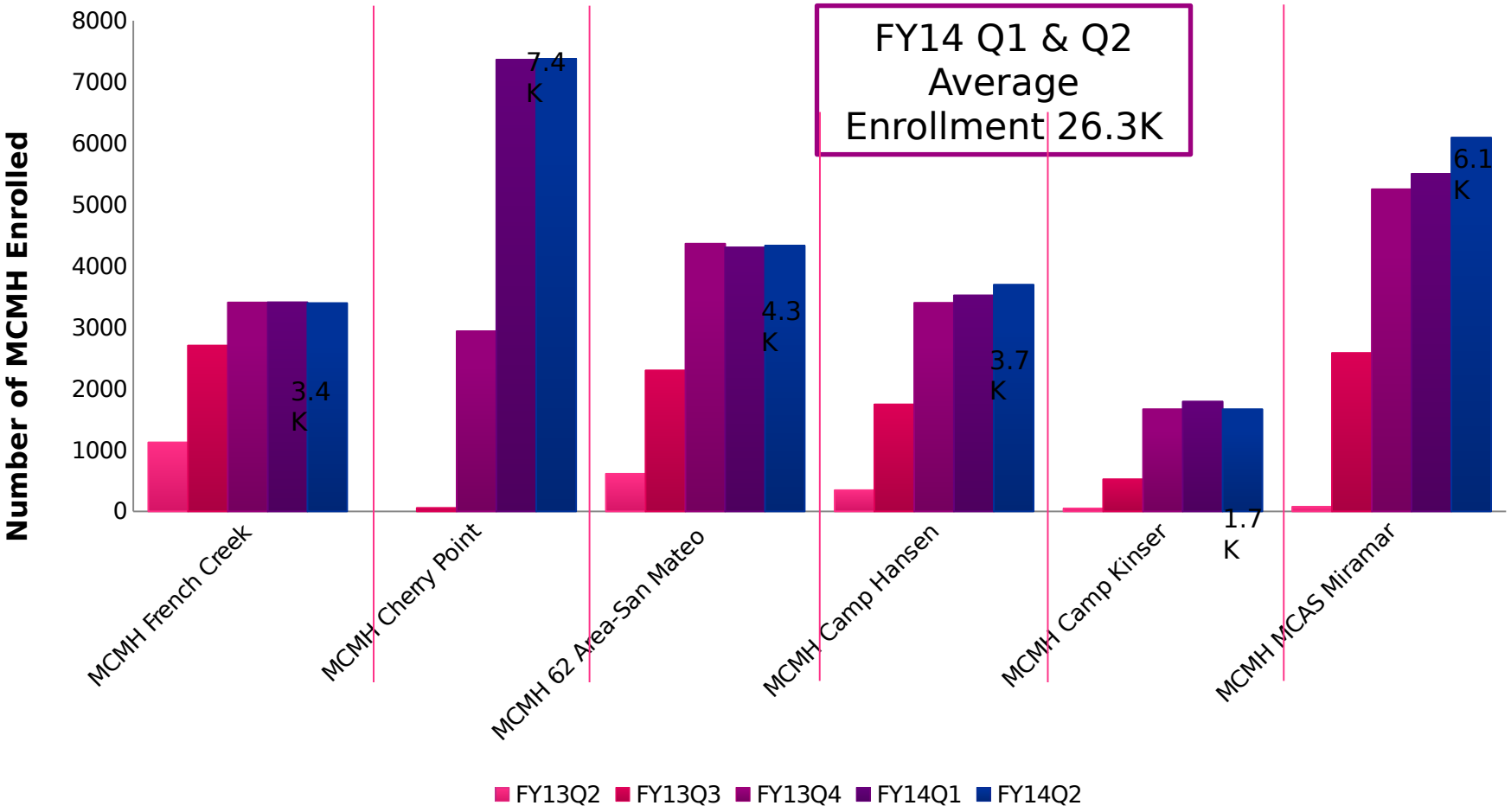
- MCMH Enrollment efforts began in January 2013. By April 2013 4,300 Marines were enrolled in a MCMH
- Through the remainder of FY13, MCMH enrollment notably grew nearly 40% each month to a peak enrollment of ~ 27K one year later in January 2014



Source: BUMED M3B7 - Data Source: MHS Mart (M2) May 2014

MCMH Enrollment

By Quarter



Source: BUMED M3B7 - Data Source: MHS Mart (M2) May 2014

Emergency Room Utilization

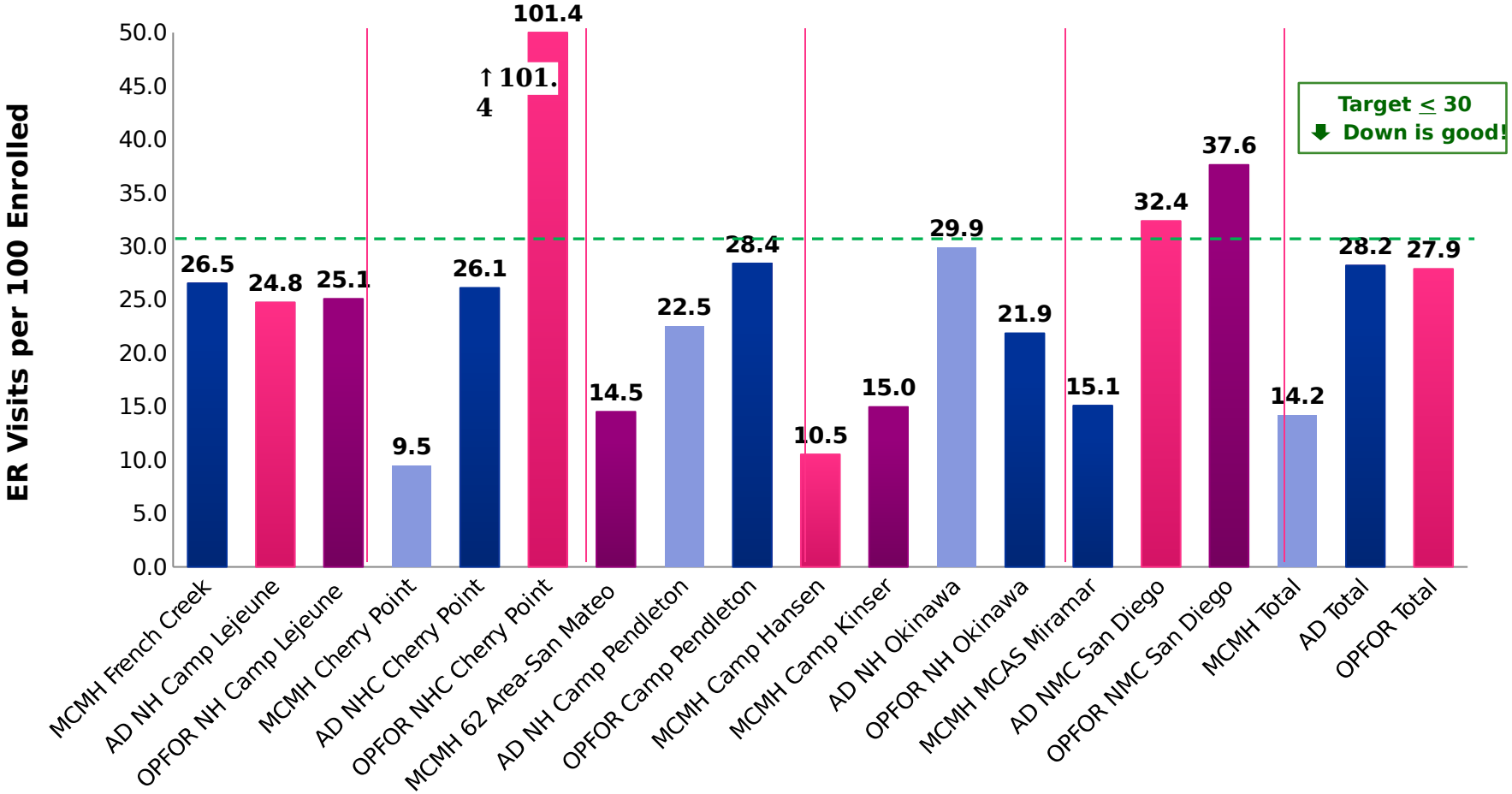
BLUF

- During CY13, MCMH enrollees had a direct care (MTF) ED utilization rate 53% lower than OPFOR Marines and 36% lower than Marines enrolled to non-MCMH clinics
- During the same period, MCMH enrollees had 33% fewer Purchased Care (civilian care) ED visits compared to OPFOR Marines and 57% fewer than non-MCMH enrolled
- Overall cost avoidance exceeds $5 MIL

ER Utilization per 100 Enrollees

Direct Care and Purchased Care

CY2013



Source: Navy and Marine Corps Public Health Center, Health Analysis Department- Data Source: MHS Mart (M2) March 2014

Enrollee population includes only active duty Marines

Team Continuity

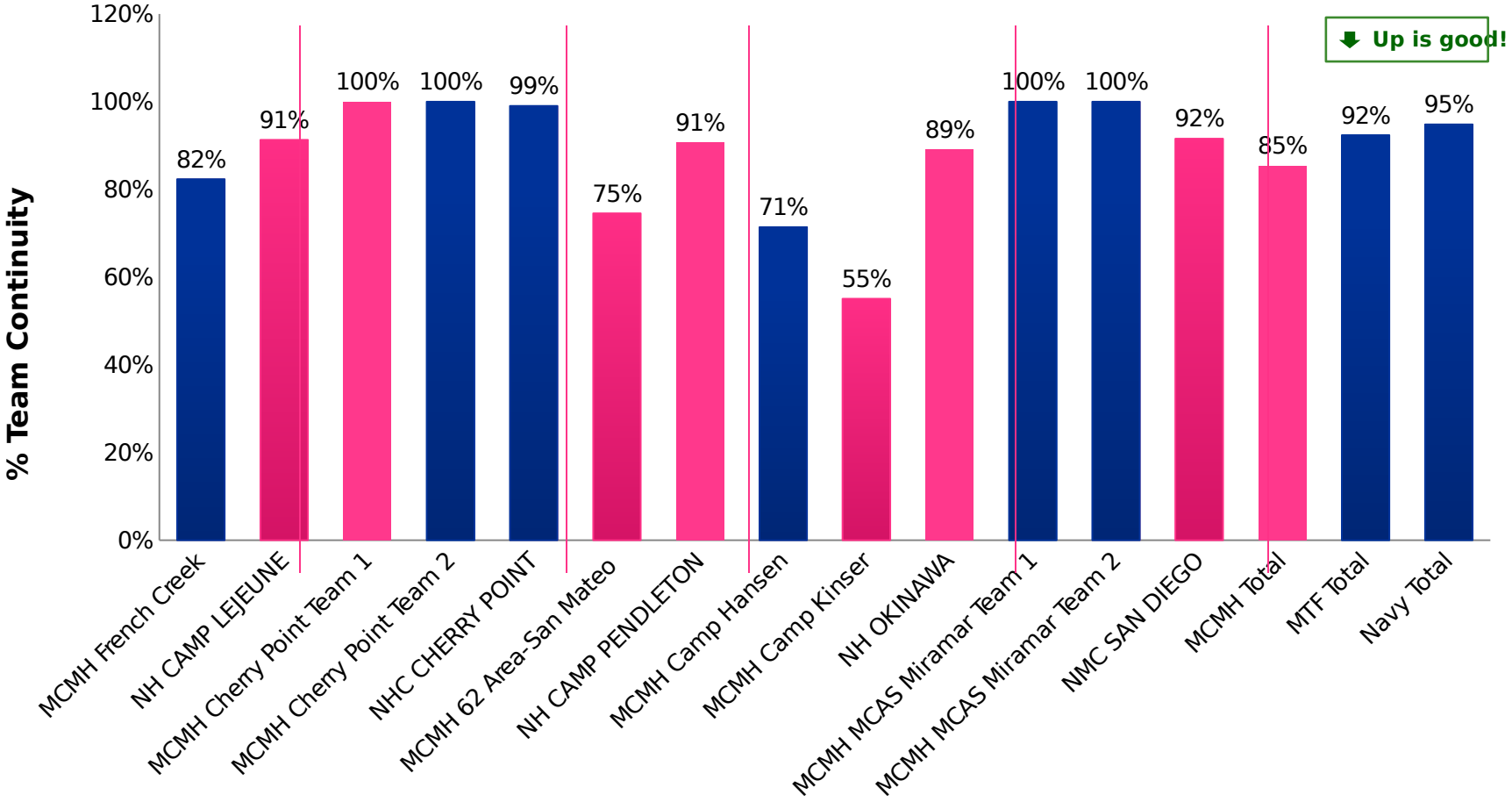
BLUF

- April 2013-March 2014 MCMH enrollees were seen by their Primary Care Manager (PCM) or a provider within their Primary Care Team 85% of the time
  - During this same period, Team Continuity at the nearby MTFs averaged 92% (not inclusive to only Marines but includes appointments for all beneficiaries) and Navy Medicine's total Team Continuity rate was 95%

Team Continuity data does not provide the same level of detail as other data sources. Therefore, comparisons to OPFOR enrolled are not possible. Instead, comparisons were made for all enrolled beneficiary types at the Parent MTF and the Navy overall.

Team Continuity

Apr 2013 – Mar 2014



Source: BUMED M3B7- Data Source: TRICARE Operations Center (TOC) April 2014

Access to Care

BLUF

- In the early stages of MCMH implementation, FY13 Q3 and Q4, access to care results were mixed
- However, the practices matured significantly and in FY14 Q1 and Q2, access to care for MCMH Enrollees, as measured by time-to the next available (open) appointment, is 15% less (better) than enrollees at proximate MTFs and 5% less than the time-to access for the entire Navy

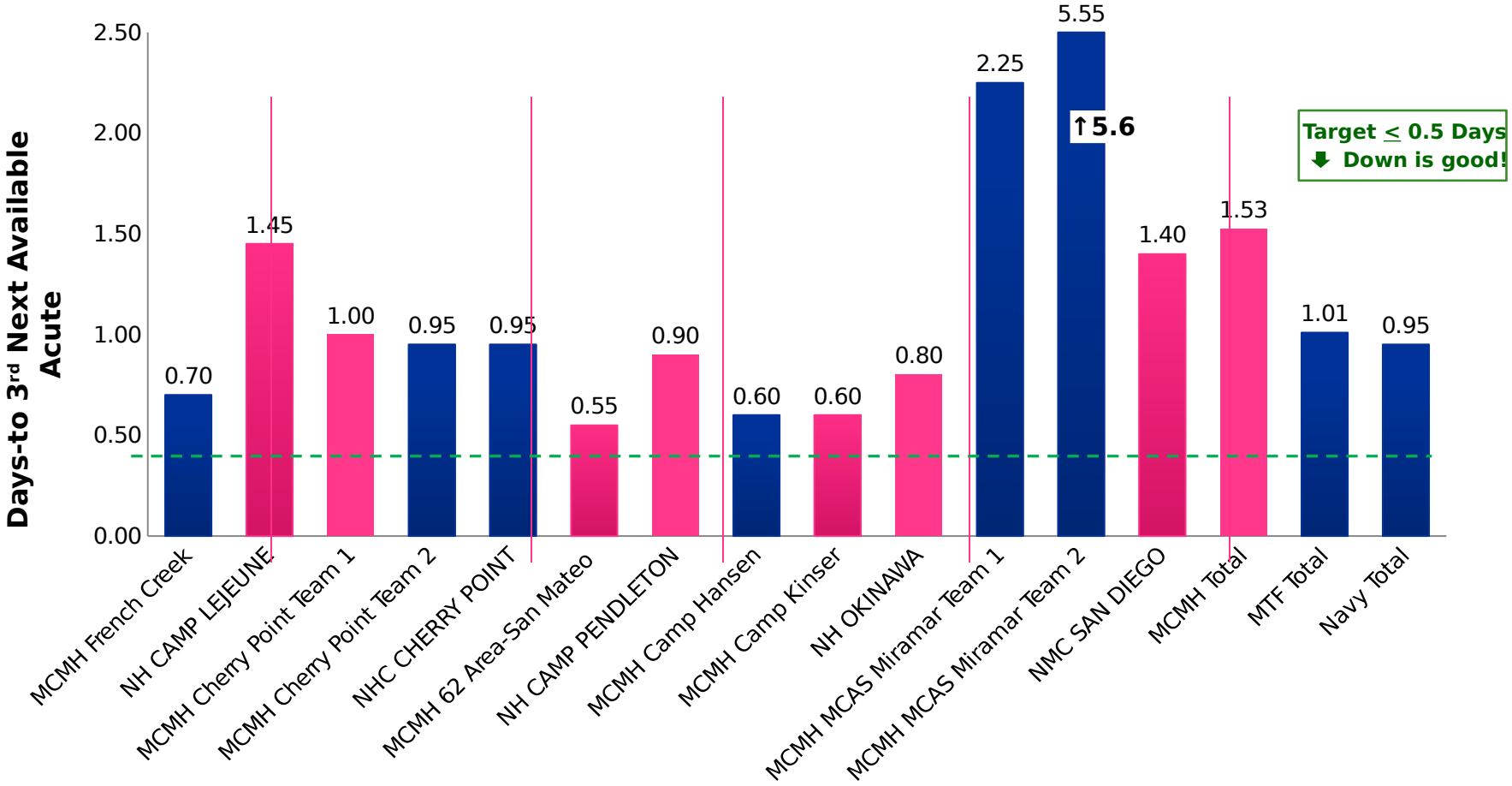
Access to care data does not provide the same level of detail as other data sources. Therefore, comparisons to OPFOR enrolled are not possible. Instead, comparisons were made for all beneficiary types at the Parent MTF and the Navy overall.

Access to Acute Care

Days-to 3rd Next Available Appointment

Early Period

Apr 2013 – Sep 2013



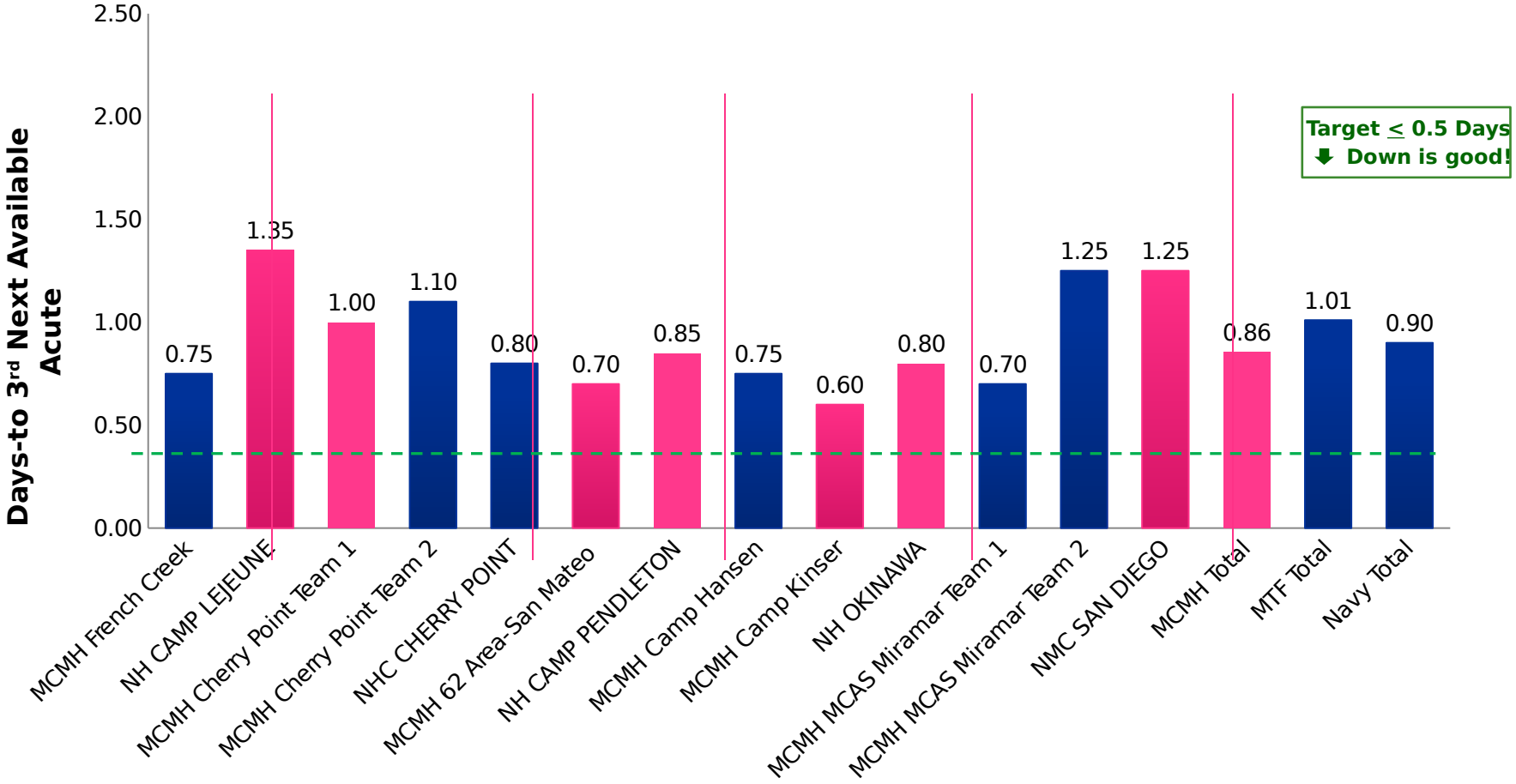
Source: BUMED M3B7- Data Source: TRICARE Operations Center (TOC) April 2014

Access to Acute Care

Days-to 3rd Next Available Appointment

Maturing

Oct 2013 – Mar 2013



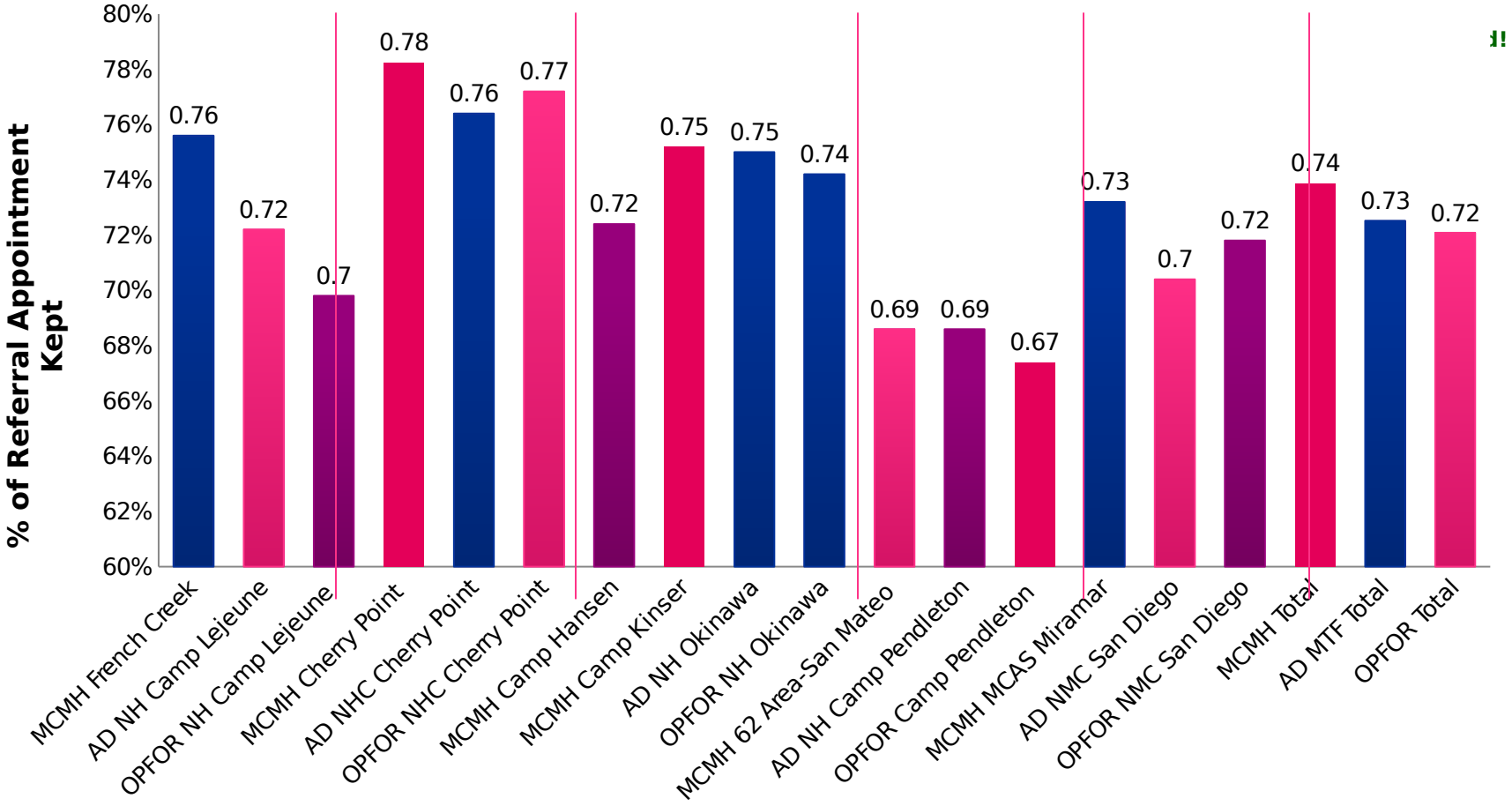
Source: BUMED M3B7- Data Source: TRICARE Operations Center (TOC) April 2014

Referral Appointments Kept

BLUF

- Since January 2013, each of the MCMH sites demonstrated a higher percentage of kept referral appointments and shorter median wait times for a referral appointment in comparison to OPFOR Marines and most non-MCMH Marines enrolled to local MTFs

Referral Appointments Kept
Jan 2013 – Mar 2014



Source: Navy and Marine Corps Public Health Center, Health Analysis Department- Data Source: MHS Mart (M2) March 2014

Enrollee population includes only active duty Marines

An initial referral can have several appointments associated with that referral (e.g., a series of mental health clinic appointments); all appointments associated with an initial referral were maintained for these analyses

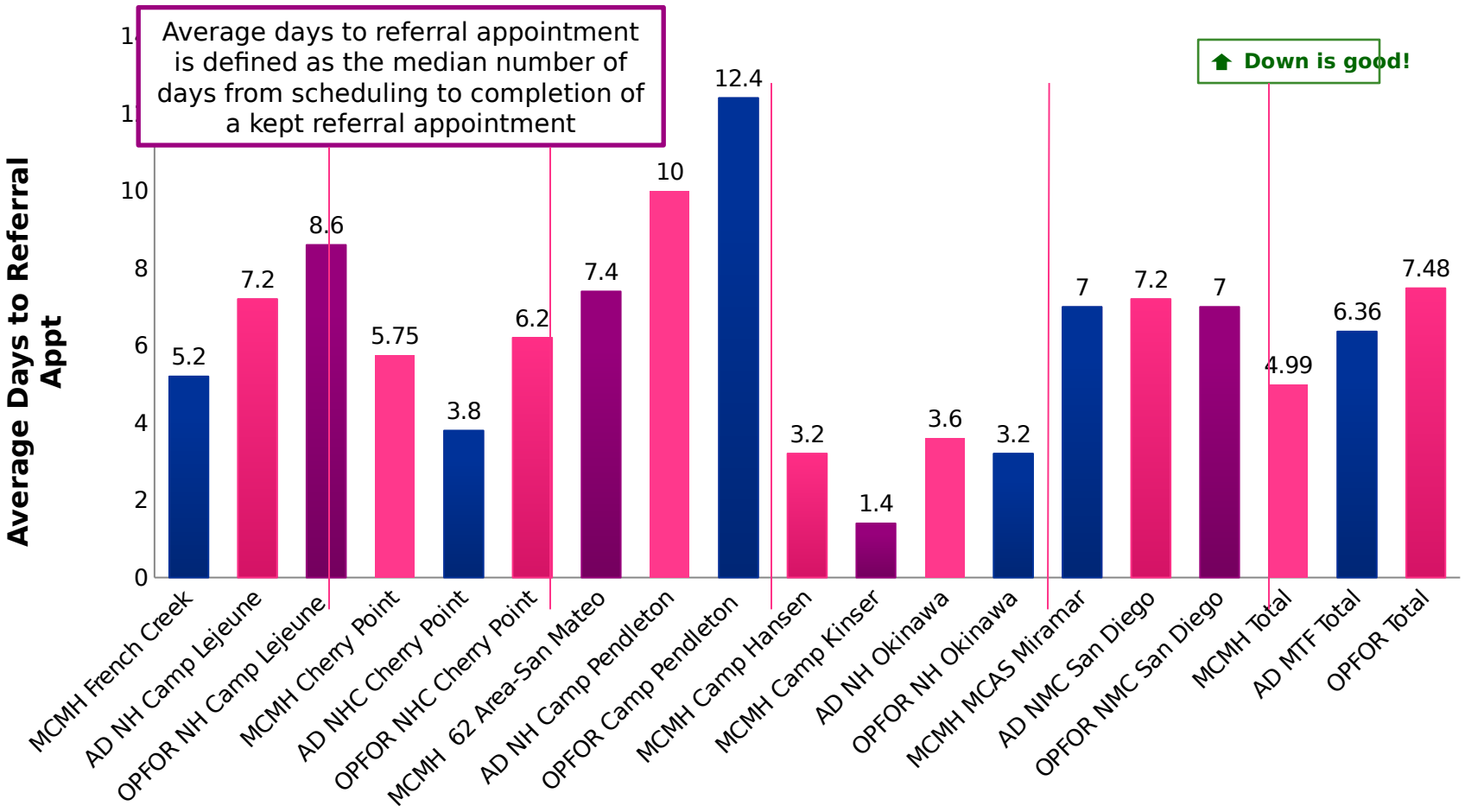
Average Days-to Referral Appointment

BLUF

- Since January 2013, the average days it takes to obtain a specialty consultation appointment for MCMH enrollees is 21% faster than Marines enrolled to proximate MTFs and 33% faster than OPFOR enrolled Marines

Average Days-to Referral Appointment

Jan 2013 – Mar 2014



Source: Navy and Marine Corps Public Health Center, Health Analysis Department- Data Source: MHS Mart (M2) March 2014

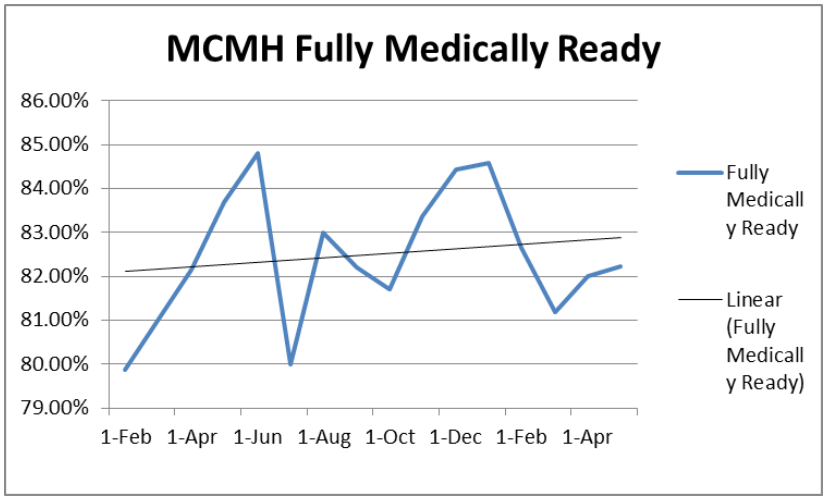
Enrollee population includes only active duty Marines

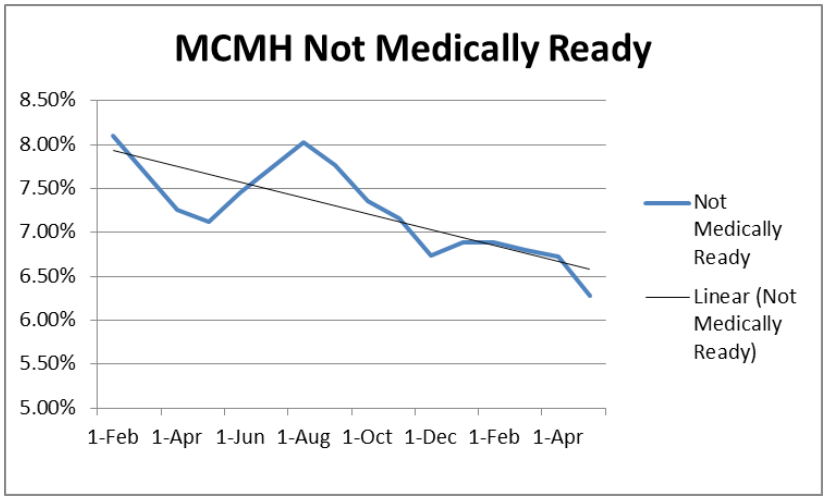
An initial referral can have several appointments associated with that referral (e.g., a series of mental health clinic appointments); all appointments associated with an initial referral were maintained for these analyses

Medical Readiness

BLUF

- Since MCMH implementation, the average number of Marines not medically ready to deploy has decreased by 22%.
- Additionally, the number of fully medically ready Marines has increased by 3% since m





Source: MRRS; Non-Deployed IMR Reports Feb 2013 – May 2014

Key Points

- Nearly 27K Marines are enrolled in a MCMH
- Controlling costs: In CY2013 ED utilization rates were ½ that of Marines enrolled to nearby MTFs and ½ of OPFOR enrolled Marines for a net cost avoidance of **$5MIL**
- Maintaining continuity: MCMH enrollees see a member of their primary care team 85% of the time
- Improving Access: MCMH enrollees have 15% greater access to same day appointments compared to Marines at nearby MTFs and 5% greater access compared to the entire Navy.
- Coordinating Care: MCMH enrollees have a higher % of kept referral appointments and shorter wait times for their appointments
- Improving Readiness: Enrolled units are maintaining >82% Fully Medically Ready status (a 3% improvement) and maintaining <6.5% Not Medically Ready (a 22% improvement).

FCMH Leadership*

- FCMH transformation is an organization-level change initiative
  - To be successful, leaders must provide active, continuous support
  - Instill confidence and enthusiasm for this challenging transformation
  - Provide motivation for continuous improvement and innovation
  - Provide support for their staff as practice teams redesign themselves and their processes to provide better quality, more accessible, and more patient-centered care

**Leadership includes CO, XO*

“If you don't like change, you're going to like irrelevance even less.”

- *General Eric Shinseki (ret.)*
Former Chief of Staff, U.S. Army

Summing It Up for Navy Medicine

- Familiar source of care = safe, quality care
- Small teams can provide coverage
- Care must be coordinated; accountable team
- Proactive, not reactive healthcare
- Documentation of care in electronic record critical
- Quality improvement activities crucial
- Evidenced based decision support
- Ready access to care with team; use of ER only when appropriate

Questions?